MDR Tracking Number: M5-04-2141-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on March 15, 2004.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. The massage therapy, therapeutic exercises, ultrasound, electrical stimulation from 05-01-03 through 05-22-03 were found to be medically necessary. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 09-28-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
05-12-03	97124 97110 97035 97032	$84.00 $105.00 $88.00 $66.00	$0	No EOB	$28.00 x 3 $35.00 x 3 $22.00 x 4 $22.00 x 3	1996 MFG	Review of the requestor and respondent's documentation revealed that neither party submitted copies of EOB's, however review of the recon HCFA reflected proof of submission. Therefore, the disputed services 97124, 97035, and 97032 will be reviewed according to the 1996 Medical Fee Guidelines. Recommend reimbursement of $238.00. See Rationale below for 97110.

05-22-03	97124 97110 97035 97032	$84.00 $105.00 $66.00 $66.00	$0	No EOB	$28.00 x 3 $35.00 x 3 $22.00 x 3 $22.00 x 3	1996 MFG	Review of the requestor and respondent's documentation revealed that neither party submitted copies of EOB's, however review of the recon HCFA reflected proof of submission. Therefore, the disputed services 97124, 97035, and 97032 will be reviewed according to the 1996 Medical Fee Guidelines. Recommend reimbursement of $216.00. See Rationale below for 97110.
TOTAL		$664.00					The requestor is entitled to reimbursement of $454.00

Rationale for CPT code 97110 - Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement not recommended.

This Findings and Decision is hereby issued this 15th day of October 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 05-01-03 through 05-22-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 15th day of October 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/pr

Envoy Medical Systems, LP
1726 Cricket Hollow
Austin, Texas 78758

Ph. 512/248-9020 **Fax 512/491-5145**
IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

July 16, 2004

Re: IRO Case # M5-04-2141, amended 8/11/04

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Orthopedic Surgery, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records

provided, is as follows:

Medical Information Reviewed

1. Table of disputed services
2. Explanation of benefits
3. Surgeon's notes
4. Discharge summary and other hospital notes
5. MRI of left shoulder report
6. NCS report
7. MRI lumbar spine report
8. X-ray reports ribs and skull
9. Physical therapy clinic notes
10. Behavioral clinic note

History

The patient is a 40-year-old male who was in a motor vehicle accident on ___, and injured his lower back, cervical spine, left shoulder and left rib cage. He also had a scalp laceration that required surgical repair. The patient was diagnosed with a hematoma and injury to the left posterior shoulder. He was also felt to have thoracic spine fractures and a head injury. The patient was treated with conservative treatment, including physical therapy and modalities, for his back and shoulder injuries. He also underwent diagnostic operative arthroscopy after MRIs showed some abnormalities. In May 2003 the patient was undergoing extensive physical therapy for his shoulder and back. The medical records provided for this review showed slow improvement with conservative treatment with regard to the lower back. However, the patient continued to have shoulder pain, and that ultimately led to the shoulder arthroscopy.

Requested Service(s)

Massage therapy, therapeutic exercises, ultrasound, electrical stimulation 5/1/03 – 5/22/03

Decision

I disagree with the carrier's decision to deny the requested services.

Rationale

The patient suffered a severe injury on ___, including thoracic compression fracture and HNP at L4-5 that required extensive physical therapy, and chronic shoulder pain and impingement that required arthroscopic debridement. The physical therapy in May 2003 was medically necessary, and the documentation provided adequately supports its necessity.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

_____